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ABSTRACT

It has been estimated that 20 to 38% of females and 10% of males have been sexually abused prior to age 18. This study reviewed the treatment literature to determine any differential interests in the topic of child sexual abuse across the disciplines of social work, psychology, psychiatry, and medicine. Ten professional journals, considered representative of these four disciplines or likely to contain a high frequency of articles on sexual abuse, were reviewed for articles relevant to child or adolescent sexual abuse. Articles addressing sexual abuse were reviewed for professional affiliation of the senior author; signs, symptoms, and effects of ongoing or past abuse; and treatment approaches. One issue from each volume of each journal was also randomly selected to gather baseline data on professional disciplines of all authors publishing in that journal. A total of 118 articles focusing directly on the signs, symptoms, effects, and treatment of child sexual abuse were found. A total of 1,327 articles were sampled to form the baseline for professional disciplines. The findings from chi-square analyses revealed a differential responsiveness to sexual abuse across professional disciplines. Articles from psychiatry and medicine were represented in the child abuse literature to the same degree as they were represented in the literature in general. Social work contributed 12% of the articles in the baseline sample and almost 33% of the sexual abuse papers reviewed. Psychology provided 38% of articles in the baseline sample, but only 18% of the sexual abuse articles. (Tables are included which list signs and symptoms of ongoing abuse, signs and symptoms of past abuse, parental signs of child sexual abuse, and therapeutic interventions described in the sample. Two bibliographies are included: one lists the 118 articles reviewed in the study, the other lists 85 related references.) (NB)

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The Representation of Psychology in the Child Sexual Abuse Literature: An Analysis and Bibliography

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The sexual abuse of children has been an issue of growing concern in recent years with the finding that an estimated 20 to 38% of females and 10% of males have been sexually abused prior to age 18 years (Finkelhor & Hotaling, 1984; Russell, 1983). Equally troubling is the finding that as many as 75% of female psychiatric inpatients have been sexually abused during their childhood and/or adolescence (Bryer, Nelson, Miller, & Krol, 1987). Accurately assessing the dimensions and impact of this social problem is difficult as only 3-5% of all abuse cases are ever reported (Finkelhor & Hotaling, 1984).

This problem is compounded by the differential responsiveness which various mental health professionals have displayed towards child sexual abuse. Snyder and Newberger (1986) demonstrated that nurses and social workers tend to rate reported incidents of abuse as much more serious than do psychologists, physicians, and psychiatrists. Wilk and McCarthy (1986) also revealed differences in the attitudes of professional groups towards child sexual abuse. When the table of contents of various professional journals are compared, it is readily apparent that certain professions publish more articles on the topic of child sexual abuse than do others. This suggests that differential levels of importance are being placed on this issue by the professionals who are most often in contact with the victims of child sexual abuse.

The present study provides a review of the treatment literature to determine any differential interests in the topic of child sexual abuse across the disciplines of social work, psychology, psychiatry, and medicine. Additionally, a list of signs and symptoms characteristic of sexual abuse victims is presented, along with a list of potential treatment approaches.

Method

Sample

Ten professional journals (listed in Figure 2) were reviewed for articles relevant to child or adolescent sexual abuse. These journals were considered representative of the disciplines of psychology, psychiatry, and social work, or as being likely to contain a high frequency of articles on sexual abuse. The review covered the period of January 1977 through December 1987. Only articles addressing the signs, symptoms, and effects of ongoing or past sexual abuse and/or their treatment were included in the review.

The authors are listed alphabetically to reflect equal contributions. Portions of this paper were presented at the Fifteenth Annual convention of the Association for Behavior Analysis, Milwaukee, WI, May, 1989. We wish to acknowledge Professor Donald J. Levis for providing the idea on which this study was based and for his useful suggestions in preparation of this manuscript. Requests for reprints may be sent to Jayne Kurkjian, who is now at the Department of Child & Family Psychiatry, Rhode Island Hospital, 593 Eddy St., Providence, RI 02903.

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Procedure

The authors reviewed the journals in the sample by scanning the table of contents of each issue for titles of articles on sexual abuse, or titles which suggested that the topic might be addressed. Each article was reviewed for the following information: professional affiliation of the senior author; signs, symptoms, and effects of ongoing and/or past abuse; and treatment approaches. Professional discipline was determined by the degree and/or institutional affiliation of the senior author. Authors were categorized into the disciplines of: social work, psychology, psychiatry, medicine, or other (which included pharmacology, physical therapy, law, rehabilitation, and nursing). One issue from each volume of each journal was also randomly selected to gather baseline data on professional disciplines of all authors publishing in that journal. Inter-rater agreement calculated on a small sample of the reviews was greater than 90%.

Results

A total of 118 articles focusing directly on the signs, symptoms, effects and treatment of child abuse were located in the sample. A total of 1327 articles were sampled to form the baseline for professional disciplines.

A one-dimensional chi-square test was performed to determine whether each discipline contributed the number of articles to the sample of 118 which would be expected from the baseline sample of 1327 articles. This analysis revealed statistically significant differences between the expected and observed frequencies, chi-square ($4, N = 118$) = 41.8, $p < .005$, and is graphically displayed in Figure 1. It can be seen that the significant effect is largely due to a higher than expected percentage of articles from those authors with social work affiliations and a lower than expected percentage from those authors with psychology affiliations.

A chi-square analysis was also performed to determine whether each of the ten journals contributed the number of articles to the sample of 118 which would be expected from the baseline sample of 1327 articles. This analysis revealed a statistically significant difference between the expected and observed frequency, chi-square ($4, N = 118$) = 72.42, $p < .005$, and is displayed in Figure 2. This effect is largely due to a higher than expected percentage of articles in journals with social work affiliations (Social Casework, Child Welfare) and a lower than expected percentage of articles in those journals with psychology affiliations (Behavior Therapy, Journal of Consulting and Clinical Psychology).

A listing of the signs, symptoms, and effects of ongoing and past sexual abuse, therapeutic interventions and parental signs was generated. Tables 1 and 2 present the signs and symptoms of ongoing abuse and past abuse, respectively. The categories in these tables represent only apparent similarities among the symptoms and are not statistically determined clusters. Table 3 presents a number of signs which may be exhibited by parents who are abusing their children. Table 4 provides a listing of the interventions which were described in the sample as being applied to cases of child sexual abuse.

Discussion

This review of the child sexual literature concurs with the above noted finding of Snyder and Newberger (1986), and Wilk and McCarthy (1986) that there is a differential responsiveness to sexual abuse across professional disciplines. It was found that articles from psychiatry, medicine, and other disciplines (excluding social work and psychology) are represented in the child sexual abuse literature to the same degree as they are represented in the literature in general (30%, 7%, and 12%, respectively). The case for social work and psychology is quite different however. Social work contributed 12% of the articles in the baseline sample, while contributing almost one third of the sexual abuse papers reviewed. Alternately, psychology provided some 38% of all of the articles in the baseline sample and only 18% of the sexual abuse articles. These findings suggest that social workers are concentrating a large share of their professional efforts on child sexual abuse, while psychologists are making a relatively smaller contribution in this area.

Adams-Tucker (1984) has stated that any and all symptoms and complaints, *including none at all*, should be taken to suggest the possibility of sexual abuse. The list of signs and symptoms compiled here would support this statement. This suggests the need for additional research comparing sexually abused and nonabused populations on the full spectrum of symptoms and effects.

The quality of research on the treatment of sexual abuse reviewed in the present study was not impressive. This review revealed only 17 treatment studies among the 118 studies reviewed (14.4%). None of these studies included an experimental control group, or even an alternate comparison treatment group. The majority of the studies did not even employ group designs, but rather used single subject designs. Clearly, there is a need for controlled treatment studies if our understanding and treatment of child sexual abuse is to advance beyond the simple identification of symptoms and providing emotional support under the guise of therapy. It is hoped that the two bibliographies included with this report will provide a literature base for such an advancement.

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Table 1

Signs and Symptoms of Ongoing Abuse

Personality characteristics: Guilt (over pleasure derived from sexual activities; over abusing parent's death); feelings of responsibility for abuse; "Cinderella syndrome" (degrading self to relieve guilt); helplessness; withdrawal; embarrassment; anger (towards parents for failure to protect, towards mother for not stopping father, denial of anger towards father); hostility; poor peer relations; protecting one or both parents; denial; low self-esteem; non-conforming; loneliness; inability to trust; dramatic changes in personality/behavior

Psychiatric diagnoses: Depression; psychosis; paranoid, schizoid, psychotic tendencies; borderline personality disorder; drug/alcohol abuse

Anxiety/phobic reactions: Phobias; stress; fear (of: disclosing abuse, males, being alone, the dark, abuser, not being believed, abandonment, punishment, blame); panic; traumatic neurosis; counterphobia (actually seeking out and engaging in the feared activity as a way of managing the associated anxiety); homophobia; refusal to sleep alone; compulsive behaviors

Sex-related problems: Precocious sexual play; promiscuity; prostitution; compulsive masturbation; provocative/seductive towards adults; initiating sexual activity with siblings, peers, adults; sexual preoccupation; sexual content in speech; denial of sexual feelings/pleasure; gender role/sexual identity confusion; homosexuality; confusion of sex with violence; sexual diseases; pregnant before age 18

Psychosomatic and sleep disturbances: Lack of appetite; pseudoseizures; convulsions; fainting; functional blackouts; hysterical symptoms (blindness, paralysis); somatization; headaches; chronic stomachaches; urinary tract infections; painful urination; pain related to physical area of attack; sleep dysfunction; recurrent nightmares (including sexual/violent themes); talking in sleep; nighttime awakening

Memory and perceptual disturbances: Illusions of violent accidents; homicidal thoughts; intrusive thoughts; amnesic episodes; misperception of time during abusive trauma; tendency to fantasize

Violent behaviors: Delinquent behavior (running away, stealing, fire-setting, other criminal activity); violent verbalizations; increased fighting with peers; aggression towards adults and peers; killing one or both parents; multiple "accidents"; suicide threats/attempts; self-injurious/self-destructive behavior (including: self-poisoning; cutting, bruising, scratching, burning [especially of breasts and genitals]; breaking bones)

Age-inappropriate behaviors: Infantile behavior; inappropriate attachment and detachment responses (clinging to parent); regression in skills; secondary enuresis (including bedwetting) and encopresis; assuming responsibility inappropriate for age (especially females)

School-related and other symptoms: School phobia; learning problems; early school arrival, late school departure; marked change in school behavior (including lower grades); scapegoat at home/school; hyperactivity

Table 2

Signs and Symptoms of Past Abuse

Personality characteristics: Low self-esteem; negative feelings toward sex/men; minimizing; passivity; dependency on males; self-blame; guilt; shame; denial; isolated; lack of trust (especially of men); highly fluctuating moods

Psychiatric diagnoses: Depression; drug/alcohol dependency/abuse; psychosis; schizophrenia; multiple personality; borderline personality disorder; women with premenstrual affective syndrome (within a psychiatric population)

Anxiety/phobic reactions: Neurotic reactions; persistent phobias; panic; agoraphobia; hypervigilance; anxiety around males; fears of punishment regarding speaking about incest; arranging to be punished by men when anxiety too high; exaggerated startle response to being touched; recurring nightmares which cause anxiety the next day

Sex-related problems: Unsatisfactory heterosexual relationships; lack of sexual intimacy; orgasmic dysfunction; other sexual dysfunction; sexual delusions and preoccupations; promiscuity; seductive; prostitution; excessive masturbation; sexual identity problems; homosexual activities; tendency to sexual victimization

Psychosomatic and sleep disturbances: Hysterectomy at early age; headaches; stomach ailments; backaches; skin disorders; excessive use of prescription and nonprescription drugs; tremors; excessive sweating; fatigue; sleep dysfunction; recurring nightmares

Memory and perceptual disturbances: Psychogenic amnesia; forgetfulness; confusion; selective attention; distractible; sexual sensations/memories; intrusive/disturbing thoughts and obsessions (about incest, sexual fantasies); intrusive memories and images; waves of intense emotions; recurring hallucinations/perceptual disturbances: (illusions; hallucinations: auditory, tactile, kinesthetic, somatic, olfactory, visual [shadowy figures, movement in peripheral vision, elaborate visions]); delusions; depersonalization; recurring dissociation

Violent behaviors: Murderous fantasies; committing rape; fear of violence towards children; impulses to kill one's own children; emotional/physical/sexual abuse of one's own children; physically abusive to wife; physically abusing elderly parents; masochism; series of suicide attempts; self-injurious/self-destructive behavior (including: self-poisoning; cutting, bruising, scratching, burning [especially of breasts and genitals]; breaking bones)

Other signs and symptoms: Younger; less likely to have completed college; more major medical problems; more frequent and longer psychiatric hospitalizations; history of abortion and sterilization; re-enact traumatic events; earlier marriage; marital problems; incest recurs between victim's husband and daughter

Table 3

Parental Signs of Child Sexual Abuse

Parent	Characteristics
Father	• Drug/alcohol abuse, may have blackouts • Excessive concern about daughter dating • Violence towards children or spouse • Absence from home • Rationalizing statements: "Girls need to be prepared for later sexual experiences" "All fathers do it" "She's promiscuous anyway" • Childhood history of abuse
Mother	• Drug/alcohol abuse • Frequently absent from home • Frequent illness/disability • Childhood history of abuse

Table 4

Therapeutic Interventions Described in the Sample

Type of therapy	• = Examples; * = Suggestions/comments
Drug therapy	• Anticonvulsants (for cases with hysterical seizures)
	• Pharmacotherapy
Play therapy	• Psychoanalytically oriented play therapy
	• Role play and dramatic play therapy (recreate scenes -- child controls content of scene)
	• Play therapy group
	• Art projects -- draw self and family
	• Body contact between child group members through nonsexual "horsing around"
	• Use of anatomically correct dolls (use child's terms for anatomy)
	* Perform early, before thoughts are suppressed
Individual therapy	• Individual object relations therapy (goal is to make traumatic memories more normal/tolerable)
	• Process-oriented/psychodynamic therapy
	• Brief supportive therapy with focus on feelings
	• Kohutian therapy
	* Stages: (1) Insight (client admits incest); (2) Emotional catharsis; (3) Transference
	* Overcome defenses and dynamics
	* Recommend same sex therapist to aid in transference and catharsis crisis
	* Follow individual therapy by family therapy
Group therapy	• Group therapy with other victims
	• Youth self-help group: support, coping strategies
	• Process oriented group therapy and/or support group
	• Group family therapy
	* Emphasize the traumatic nature and sequelae of abuse
	* Include sex education and discussion of incest
	* Intent is to resolve shame and guilt, and to decrease isolation
Family therapy	• Family systems orientation
	• Family dynamics orientation
	• Structural family therapy (redefine family boundaries)
	* Family viewed as analogous to a character disordered individual
Marital therapy	• Conjoint therapy (both spouses)
	• Ten-week semistructured therapy group for couples
	* Concentrate on sexual issues of both spouses
Behavior therapy	• Implosive therapy
	• Behavioral techniques
Other	• Crisis intervention, hotline
	• Residential treatment
	• Electroconvulsive therapy
	* Give client a sense of control over therapy
	* Enhance self-concept
	* Offer support
	* End the abuse, protect victim
	* Remove abused or abuser from home
	* Encourage expression of emotions (e.g., fear, anger, guilt, self-blame, responsibility)
	* Multidisciplinary approach, includes: psychiatrist, psychologist, pediatrician, police, social worker, clergy, school, nurse

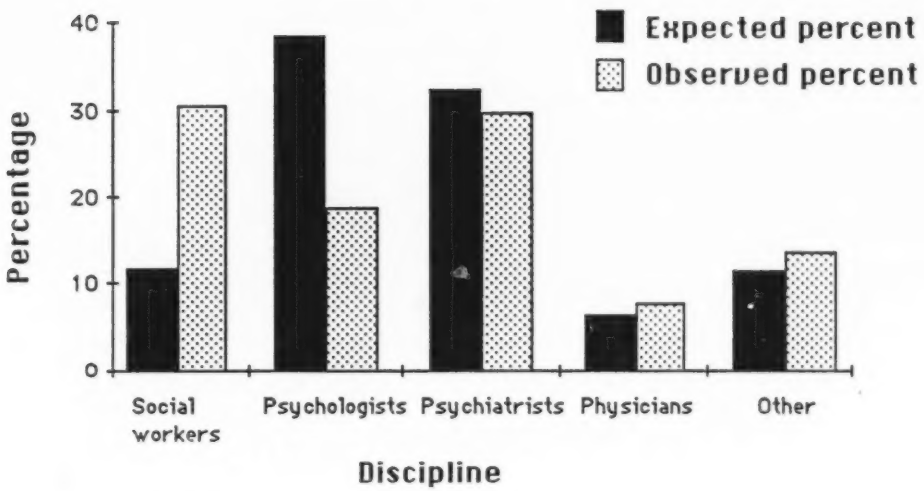

Figure 1. Expected and observed percentages of sexual abuse articles for professional disciplines sampled.

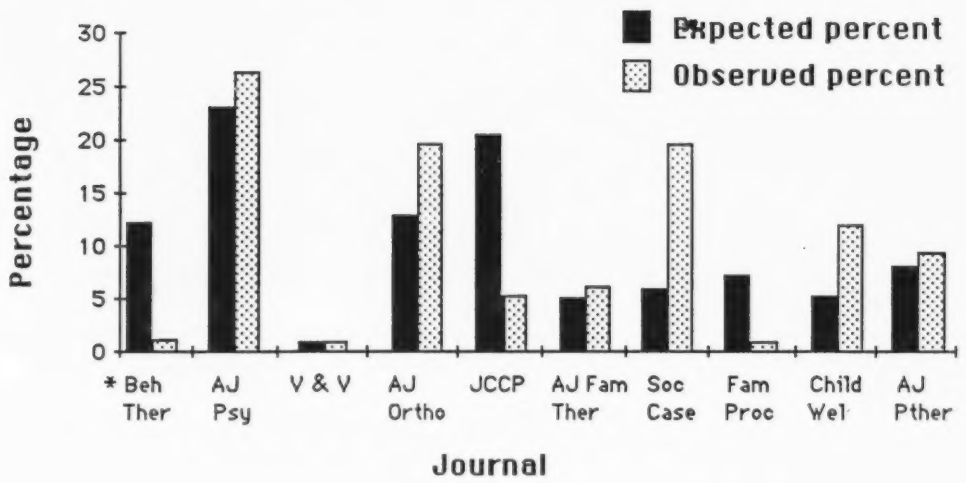

Figure 2. Expected and observed percentages of sexual abuse articles for journals reviewed.
Chi-squared = 72.42, df = 9, $p < .005$.

* Note: Beh Ther = Behavior Therapy; AJ Psy = American Journal of Psychotherapy; V & V = Violence and Victims; AJ Ortho = American Journal of Orthopsychiatry; JCCP = Journal of Consulting and Clinical Psychology; AJ Fam Ther = American Journal of Family Therapy; Soc Case = Social Casework; Fam Proc = Family Process; Child Wel = Child Welfare; AJ Pther = American Journal of Psychotherapy

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